



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

ELITE HEALTHCARE - GARLAND

**Respondent Name**

HARTFORD INSURANCE COMPANY

**MFDR Tracking Number**

M4-15-0020-01

**Carrier's Austin Representative Box**

Box Number 47

**MFDR Date Received**

SEPTEMBER 2, 2014

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "The attached date of service has been denied 'UNNECESSARY MEDICAL TREATMENT BASED ON PEER REVIEW.' I do understand that a PEER REVIEW IS ON FILE, BUT PER Rule 408.201 Entitlement of Benefits, this claim should be paid. The carrier paid all previous dates of service and dates of service preceding this claim date at 100%. I am unsure as to why I can't get these dates of service paid."

**Amount in Dispute:** \$2,810.64

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The Requestor has not timely requested Reconsideration, in violation of 28 TAC § 133.250(b)... The requestor has failed to comply with the requirements of 28 TAC § 133.307(c)(2)(K) and (L). The bills in dispute were denied based up extent of injury according to the two EOBs (for DOS 9/9/13 and 9/10/13, only) included in the Request."

**Response Submitted by:** FLAHIVE, OGDEN & LATSON

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 21, 2013 through September 10, 2013	Professional Services	\$2,810.64	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services for dates of service (September 9, 2013 and September 10, 2013, only) in dispute were reduced/denied by the respondent with the following reason codes:
  - 219 – Based on extent of injury

## **Issues**

1. Did the requestor file the dispute timely?
2. Did the requestor make a request for an EOB for the dates of service for which there are no EOBs?
3. Did the requestor submit dates of service with extent of injury issues?

## **Findings**

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the service in dispute are August 21, 2013 and August 26, 2013. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on September 2, 2014. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.
2. §133.307(C)(2)(K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB. Review of the submitted documentation finds that the requestor has not submitted EOBs for dates of service September 3, 2013 through September 5, 2013 and September 23, 2013. A request for EOB's was made by the Division on September 4, 2014; however, there was not response from the requestor. Therefore, these dates of service are not eligible to be reviewed.
3. The medical fee dispute referenced above contains unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical billing process.

28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f)(3)(C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent of injury dispute for the claim. 28 Texas Administrative Code § 133.307( c)(2)(K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

The Division hereby notifies ELITE HEALTHCARE - GARLAND that the appropriate process to resolve the issue(s) of extent of injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1. As a courtesy to ELITE HEALTHCARE - GARLAND, instructions on how to file for resolution of the extent of injury issue are attached. The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code § 133.307. 28 Texas Administrative Code § 133.307(c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the extent-of-injury dispute.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

## **Authorized Signature**

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Signature

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Medical Fee Dispute Resolution Officer

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November 6, 2014  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**